LOUISIANA PATIENT'S COMPENSATION FUND

MANAGEMENT COMPANY APPLICATION

(for those with underlying self-insurance or primary coverage)

NAME AND PHYSICAL ADDRESS OF MANAGEMENT COMPANY

_____

_____

_____

_____

DATES OF ENROLLMENT APPLYING FOR:_____

(Must coincide with dates of underlying coverage if applicable)

LIST ALL LOUISIANA HEALTHCARE PROVIDERS MANAGED BY ABOVE COMPANY:

Does the company manage other healthcare related facilities outside of LA? **YES / NO** please circle

If yes, in what states?_____

For Self Insured, I further certify that the appropriate security (proof of financial responsibility) is in place and current at _____institution.

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy.

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

CONTACT PERSON AND PHONE #:_____

CONTACT EMAIL ADDRESS:_____

Complete and return to: **Patient's Compensation Fund**
P. O. Box 3718
Baton Rouge, LA 70821
Fax: (225) 362-5265